



Complete Summary

GUIDELINE TITLE

Psychological factors in chronic pelvic pain. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Psychological factors in persistent chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 77-84. [42 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

- Persistent chronic pelvic pain
- Psychological distress associated with urogenital pain including anxiety, depression, and sexual and physical abuse in childhood

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Obstetrics and Gynecology
Psychiatry
Psychology
Urology

INTENDED USERS

Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To help urologists integrate psychological understanding in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Patients with chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

Assessment of psychological factors associated with pain

- Anxiety, particularly unwarranted fears about cause of pain
- Depression
- History of sexual and physical abuse in childhood

Management/Treatment

Psychological interventions directed at pain and adaptation to pain

- Relaxation, hypnosis, biofeedback
- Physical retraining
- Behavioural change and increasing activity
- Cognitive therapy
- Educational counselling combined with ultrasound
- Multidisciplinary pain management for well-being

MAJOR OUTCOMES CONSIDERED

- Pain scores
- Symptom scores
- Sexual functioning
- Quality of life
- Mood change
- Health care resource use

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Both PubMed and PsychInfo were searched to access trials published in psychology journals not covered by medical databases, with a search covering the last 10 years, since psychological trials tend to take longer to run and to reach publication than medical and other clinical trials. The Cochrane database was also searched.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

- A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
- B. Based on well-conducted clinical studies, but without randomized clinical studies
- C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the level of evidence (**1-4**) and grade of recommendation (**A-C**) are provided at the end of the "Major Recommendations."

Assessment Recommendations (see table titled 'Psychological Factors in the Assessment of Chronic Pelvic Pain' below)

A psychologist (or equivalent) is not required for this level of assessment, but access to regular discussion with a psychologist enables the clinician to interpret better the results of assessment.

Anxiety

It is important to obtain the patient's view of what is wrong or of what the patient is worried might be causing pain and other symptoms. Investment in establishing a trusting therapeutic relationship with the patient pays off when these questions are asked. One suggestion is to ask the patient, 'What do you believe or fear is the cause of your pain'?

Investigations and results of examination should be explained clearly, in terms of what they can show, what they did or didn't show, and how this helps the investigations, attempts at diagnosis, or plans for treatment. This requires an adequate model of pain. Brief reassurance alone provides (at best) short-term relief of anxiety, after which the patient returns to seek help with the problem and the anxiety.

Depression

If the patient admits a depressed mood and attributes it to pain, it may be that the patient is interpreting information about and experience of pain and other symptoms in catastrophic ways. Good information can counteract this (as in anxiety). It may also be that the pain has had a serious impact on the patient's life; roles and satisfactions are lost because of pain, but can return with effective treatment. Encouragement to consider how to recover valued activities, with or without some pain relief, is helpful but the patient may require advice on how to do this from a pain management team.

Sexual and Physical Abuse in Childhood

It is important to consider the possibility of physical and sexual abuse when taking the history, but disclosure can be difficult before a therapeutic relationship is established. It is not clear that pain, which the patient attributes to childhood sexual or physical abuse, should be managed any differently. Any disclosure of current physical or sexual abuse should be referred immediately to appropriate health, social or welfare services.

Table: Psychological Factors in the Assessment of Chronic Pelvic Pain

Assessment	Level of Evidence	Grade of Recommendation	Comment
Anxiety about cause of pain: 'Are you worried about what might be causing your pain?'	1a	C	Studies of women only: men's anxieties not studied
Depression attributed to pain: ask 'How has the pain affected your life?' 'How does the pain make you feel emotionally?'	1a	C	Studies of women only: men's anxieties not studied
Multiple physical symptoms/general health	1a	C	
History of sexual or physical abuse	1a	C	Current/recent abuse may be more important

Psychological Factors in Treatment of Pelvic Pain (see table titled 'Treatment Factors In the Management of Chronic Pelvic Pain' below)

Untreated, there is a significant likelihood of symptom improvement. A follow-up study of women with pelvic pain referred to a clinic showed that 25% reported recovery (nearly half of them total recovery) over the 3 to 4 intervening years. However, neither pain nor distress at baseline, nor intervention received, was found to be associated with recovery.

Other sections cover the various physical (surgical, pharmacological, physiotherapeutic) interventions for male and female pelvic pain, and their outcomes. Psychological interventions may be directed:

1. At the pain itself, with the intended outcome of pain reduction and consequent reduction of impact of pain on life
2. At adjustment to pain, with the intended outcome of improved mood and function and reduced healthcare use, with or without pain reduction

The first category of interventions includes relaxation and biofeedback methods of controlling and decreasing pain by reducing muscle tension. Such methods are being applied to pelvic floor retraining, both in men and women, sometimes alongside other physical therapies (see the National Guideline Clearinghouse (NGC) summary of the European Association of Urology (EAU) guideline [Pelvic Floor Function and Dysfunction](#)).

In the second category of interventions (see above), multicomponent pain management, involving education, physical retraining, behavioural change and increasing activity, relaxation, and cognitive therapy, is often applied to mixed groups of chronic pain patients, including those with pelvic pain, but there have been no randomized controlled trials of pelvic pain groups.

A meta-analysis concluded in favour of educational counselling combined with ultrasound scan, which improved pain and mood; and a multidisciplinary rehabilitative approach, including surgery, pharmacotherapy, physiotherapy, and psychosocial intervention, which improved function but not pain. A selective serotonin reuptake inhibitor antidepressant made no improvement in pain but improved function. Consultation using a photograph taken during laparoscopy had no effect; emotional disclosure (a stress reduction method) through writing brought about very small improvement in some pain scores.

Mood change is a particular issue since, intentionally or not, any intervention, and even a good consultation can bring about cognitive, emotional, and/or behavioural change. Enabling the patient to understand what is causing the pain, and therefore the implications of the pain for everyday life and longer-term life goals, can be a major influence on the patient's successful management of pain.

Table. Treatment Factors in the Management of Chronic Pelvic Pain

Treatment	Level of Evidence	Grade of Recommendation	Comment
Tension-reduction; relaxation, for pain reduction	1b	A	Relaxation +/- biofeedback +/- physical therapy; mainly male pelvic pain
Multidisciplinary pain management for well-being	(1a)	(A)	Pelvic pain patients treated within larger group: no specific pelvic pain trials

Definitions:

Levels of Evidence

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2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

Grades of Recommendations

- A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
- B. Based on well-conducted clinical studies, but without randomized clinical studies
- C. Made despite the absence of directly applicable clinical studies of good quality

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate evaluation, management, and treatment of potential psychological factors related to persistent chronic pelvic pain

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which

- should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.
- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.
 - The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & <http://www.urosource.com/diseases/>).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Psychological factors in persistent chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 77-84. [42 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Chronic Pelvic Pain guidelines writing panel have provided disclosure statements on all relationships that they have and that might be perceived as a potential source of conflict of interest. This information is kept on file in the European Association of Urology Central Office database. This guideline document was developed with the financial support of the European Association of Urology (EAU). No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [European Association of Urology Web site](#).

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on December 30, 2008. The information was verified by the guideline developer on February 27, 2009.

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